



## INFARTO AGUDO DO MIOCÁRDIO NA EMERGÊNCIA: Revisão de Literatura

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### REVISÃO DE LITERATURA

**Resumo:** O infarto é uma doença clínica grave com alto risco de óbito causado pela oclusão de um hospital coronário epicárdico. O objetivo deste artigo é examinar as principais abordagens para abordagem de emergência com pacientes que sofreram infarto agudo do miocárdio . Metodologia : Uma revisão sistemática da literatura foi realizada a partir de 17 artigos anexados à plataforma BVS . Esses artigos apresentam as principais técnicas empregadas em emergências relacionadas ao infarto agudo do miocárdio. Resultados: A abordagem inicial de atendimento deve ser rápida e imparcial, começando com uma avaliação dos sintomas e características da dor torácica, bem como uma história pregressa relevante, um exame físico direcionado e um eletrocardiograma. Considerações: a demora no atendimento de casos de IAM pode piorar a situação do paciente e tornar mais difícil para a equipe de emergência abordá-los. Observe-se ainda que os serviços de saúde pública atenderam essas doenças de forma precária e não seguiram protocolos, o que levou a mais casos de infarto nas emergências.

**Palavras-chave:** Emergência, Infarto, Cuidados, Protocolos

# ACUTE MYOCARDIAL INFARCTION IN THE EMERGENCY: Literature review

**Abstract:** Heart attack is a serious clinical disease with a high risk of death caused by the occlusion of an epicardial coronary hospital. The objective of this article is to examine the main approaches for emergency management of patients who have suffered an acute myocardial infarction. Methodology: A systematic review of the literature was carried out using 17 articles attached to the BVS platform. These articles present the main techniques used in emergencies related to acute myocardial infarction. Results: The initial approach to care should be rapid and impartial, beginning with an assessment of the symptoms and characteristics of chest pain, as well as a relevant past history, a targeted physical examination, and an electrocardiogram. Considerations: Delays in treating AMI cases can worsen the patient's situation and make it more difficult for the emergency team to approach them. It should also be noted that public health services treated these diseases poorly and did not follow protocols, which led to more cases of heart attacks in emergencies.

**Keywords:** Emergency, Heart attack, Care, Protocols

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## INTRODUÇÃO

Apesar dos esforços da assistência preventiva às doenças cardiovasculares nas últimas décadas, foram responsáveis por 340.284 mortes no país em 2014; dentre elas, o infarto agudo do miocárdio (IAM) que ainda configura um impacto na saúde pública.

De acordo com Parana (2016, p.10) “cerca de 45 a 60% das mortes por IAM ocorrem na primeira hora do evento e 80% da mortalidade nas primeiras 24 horas. Portanto, a maior parte dos óbitos ocorre fora do ambiente hospitalar, geralmente sem assistência médica.”

Diante de tais fatos, foi criada a V Diretriz sobre o tratamento do infarto agudo do miocárdio em 2015, um documento que tem como objetivo contribuir para o progresso da Cardiologia brasileira, servindo de consulta e orientação para o médico e para o cardiologista, para que assim possa reduzir, por intermédio de sua correta aplicação, a morbidade e a mortalidade decorrentes do infarto agudo do miocárdio em nosso meio. Mas será que através dessa diretriz, esses conhecimentos são o suficiente para que seja feito um atendimento de qualidade? E será que todos os médicos estão preparados para esse tipo de abordagem de IAM?

A motivação para o desenvolvimento do trabalho, foi a observação que parte significante dos médicos atuantes nas unidades de emergências são de médicos generalistas e apresentam elevada rotatividade profissional. Dessa forma nem todos estão preparados para o atendimento de casos de IAM. Alguns autores citam a importância de elaborar programa de treinamento, com aulas teóricas e práticas, focando no reconhecimento do paciente com suspeita de IAM através da tríade: rápida triagem, diagnóstico precoce, identificação do grau de gravidade, e assim dar início ao tratamento correto. Visto que muitos profissionais apresentavam insegurança e não possuíam as noções básicas de eletrocardiograma e dessa forma temiam receber esses pacientes e iniciar o tratamento correto. Autores afirmam que a avaliação correta, o rápido diagnóstico e o início do tratamento adequado previnem as lesões decorrentes desse quadro clínico.

Portanto, o objetivo desse artigo é analisar as principais condutas em emergências frente a pacientes com infarto agudo do miocárdio, afim de evitar os casos de óbitos decorrentes do infarto.

Para a realizar o artigo foi realizada uma revisão bibliográfica com as seguintes etapas: determinar hipóteses e objetivos; determinar critérios de inclusão e exclusão de artigos; definir as informações escolhidas dos artigos selecionados; analisar os resultados e discussão e apresentar os resultados. Para a seleção dos artigos foi utilizada a base de dados: BVS (Biblioteca virtual em saúde), SCIELO e Revista de enfermagem de UFSM. Os critérios de inclusão dos artigos definidos no site da BVS, inicialmente, para a presente revisão integrativa foram utilizados três filtros de seleção: texto completo, idioma português e assunto principal, artigos esses compreendidos no período entre 2013–2018.

As palavras-chaves utilizadas no filtro assunto principal foram: cardiopatia, emergência, pacientes e infarto. A busca foi realizada pelo acesso on-line e, utilizando os três filtros de inclusão, mais outros sites, o resultado final desta revisão literária foi constituído de 17 artigos. Os resultados e discussão dos dados obtidos foram apresentados de forma descritiva, afim de que o leitor compreenda o objetivo desse método, ou seja, impactar positivamente na qualidade da abordagem de pacientes com infarto agudo do miocárdio na emergência. Os resultados foram analisados a luz da V Diretriz sobre o tratamento do infarto agudo do miocárdio de 2015.

Segue abaixo na tabela que mostra as palavras chaves dos artigos pesquisados no site da BVS, os filtros, quantidade de artigo em cada filtro e quantos artigos por palavras chave foram selecionados para serem usados na confecção desse artigo.

**Quadro 1 – Resumo dos achados por palavras chave**

Palavra Chave	Cardiopatia	Emergência	Paciente	Infarto
Site	BVS	BVS	BVS	BVS
Data da pesquisa	23/08/2018	25/08/2018	26/08/2018	27/08/2018
Sem filtro	103.035 artigos	244.851 artigos	670.678 artigos	204.385 artigos
Filtro texto completo	30.143 artigos	84.027 artigos	250.973 artigos	59.200 artigos
Filtro Idioma Português	1.190 artigos	6.994 artigos	48.069 artigos	1.947 artigos
Assunto Principal IAM*	55 artigos	80 artigos	353 artigos	65 artigos
Artigos selecionados	5 artigos	5 artigos	3 artigos	4 artigos

Fonte: Os autores (2018)

## 1. Desenvolvimento

Analisando os dezessete artigos selecionados de acordo com os critérios de inclusão previamente estabelecidos, apresentamos uma visão geral dos artigos avaliados. O Infarto Agudo do Miocárdio – IAM - é a principal causa de mortalidade e de morbidade em países desenvolvidos e em desenvolvimento, inclusive no Brasil. Identificar o IAM nas primeiras horas após início dos sintomas reduz a mortalidade dessa doença. Infarto Agudo do Miocárdio Segundo a Organização Mundial de Saúde (OMS), a taxa de mortalidade das doenças cardiovasculares manteve-se nos últimos anos entre 28 a 34 milhões de óbitos no mundo, com previsão de que até 2030 seja maior que 35 milhões (YUGAR, 2014). Segundo Dionizio (2017, p.16)

“O IAM significa basicamente a morte de cardiomiócitos devido exposição prolongada à isquemia, causada por trombose ou vasoespasmo sobre uma placa aterosclerótica, tendo como consequência falência contrátil, arritmias, estimulações do sistema nervoso simpático, dor entre outras.”

Além disso, o infarto se caracteriza por ser uma situação clínica grave, com risco eminente de óbito, que é determinada por oclusão de uma artéria coronária epicárdica. A abordagem inicial no atendimento deve ser rápida e objetiva, começando pela avaliação das características da dor torácica e dos sintomas associados, história pregressa relevante, pelo exame físico direcionado e realização do eletrocardiograma (ECG).

Segundo Yugar (2014, p.140-147),

“Emergências cardiovasculares são as mais comuns e os tipos de lesões predominantes são: Síndrome coronariana aguda, Infarto agudo do miocárdio, angina pectoris, insuficiência cardíaca, edema agudo de pulmão, dissecção aguda de aorta”.

A fim de determinar uma avaliação e atendimento de até 10 minutos à chegada do paciente na emergência, recomenda-se a aplicação do Sistema Manchester de Classificação de Risco (SMCR) que foi criado para permitir ao profissional médico e enfermeiro, habilidade para a atribuição rápida de uma prioridade clínica do paciente em situação aguda baseado em categorias de sinais e sintomas. A classificação de risco não propõe estabelecer diagnóstico clínico. Este sistema pretende assegurar que a atenção médica ocorra de acordo com o tempo resposta determinado pela gravidade clínica do paciente (GBRC, 2018).

O diagnóstico correto e precoce da síndrome coronariana aguda, juntamente do gerenciamento do protocolo de dor torácica, pode diminuir a mortalidade por IAM. (PETERSEN, 2018)

De acordo ainda com o GBRC (2018) a realização de eletrocardiograma deve ser realizada após o estabelecimento, pela classificação de risco, como Dor Torácica ou quando o discriminador escolhido for “dor precordial ou cardíaca” ou “dor epigástrica”. Assim, o médico terá um maior poder de decisão durante o primeiro atendimento, otimizando e aumentando a qualidade do atendimento e diminuindo o tempo de permanência no serviço.

É importante fazer as primeiras pesquisas em relação os principais sintomas, como a dor torácica, identificar sinais e sintomas de insuficiência ventricular esquerda, palpitações, ritmo cardíaco, ritmo de galope, dispneia, estase jugular, sopro carotídeo, pulsos periféricos e aferição da PA (três medidas). Exploração abdominal básica: detecção de massas pulsáteis, sopros abdominais e de pulsos femoriais e exames complementares como eletrocardiograma, e os menos essenciais na emergência, a radiografia de tórax, ecocardiograma, enzimas cardíacas (YUGAR, 2014).

Além dessas orientações, seguir uma rotina de investigação para tomada de decisão rápida, reduz a morbimortalidade do paciente, e permite melhor conduta da equipe médica na emergência, associada às ações descritas da equipe interdisciplinar atuante em prol do infartado, outras são sugeridas no quadro 2.

**Quadro 2: Condutas de avaliação e intervenção na emergência ao paciente com suspeita de IAM.**

Conduta	Investigação / intervenção
Anamnese (breve na classificação de risco)	<ul style="list-style-type: none"><li>• aparência de doença grave, agitação, ansiedade;</li><li>• hipotensão ou hipertensão;</li><li>• taquicardia ou bradicardia;</li><li>• sudorese (frequente);</li><li>• Sudorese, náusea ou vômitos podem estar presentes nos pacientes com ou sem dor torácica.</li><li>• evidências de má perfusão periférica podem ocorrer; B4 (evidencia disfunção diastólica), B3 (evidencia disfunção sistólica), sopro sistólico apical é comum, hipofonese de bulhas pode ocorrer; estertores pulmonares (secos e úmidos) em caso de congestão;</li><li>• turgência jugular quando complicado com insuficiência cardíaca;</li><li>• oligúria no baixo débito.</li></ul>
Exame físico	<ul style="list-style-type: none"><li>• aferição dos dados vitais, palpação de pulsos, identificação de sinais clínicos de gravidade;</li><li>• A frequência cardíaca pode variar de uma bradicardia</li></ul>

	<p>profunda, resultado de reflexo vagal, até a taquicardia sinusal irregular por extrassistolia. Os pacientes normotensos podem se apresentar levemente hipertensos devido à resposta adrenérgica;</p> <ul style="list-style-type: none"><li>• Analisar o tipo de dor: A dor “torácica” pode se manifestar da mandíbula até o epigástrico, incluindo os membros superiores. A dor é contínua, geralmente intensa, sem relação com esforço físico. Investigar se o paciente apresentou sintomas de dor anginosa nas últimas quatro semanas. O infarto sem dor é mais frequente em indivíduos idosos e manifesta-se usualmente por dispneia súbita ou sinais de insuficiência cardíaca.</li></ul>
Condutas na suspeita de IAM	<ul style="list-style-type: none"><li>• Instalar a monitorização cardíaca contínua e saturação de oxigênio.</li><li>• Deve-se fazer um ECG de 12 derivações, complementado com derivações direitas (V3R E V4R) e dorsais (V7 e V8) se infarto inferior. O eletrocardiograma durante o infarto agudo do miocárdio apresenta alterações progressivas à medida que aumenta a duração do Infarto. Em pacientes com sintomas sugestivos, a elevação do segmento ST tem especificidade de 91% e sensibilidade de 46% para diagnóstico de IAM. O índice de óbito aumenta com o número de derivações no eletrocardiograma com supradesnível de ST. A avaliação de traçados seriados deve ser feita, já que nas primeiras horas ele não é tão específico.</li><li>• Puncionar acesso venoso periférico, com dispositivo de grosso calibre.</li><li>• Solicitar exames laboratoriais: marcadores cardíacos, eletrólitos e coagulação.</li><li>• Iniciar o tratamento conforme resultados de exames</li></ul>

**Fonte:** (YUGAR, 2014; ISAA, 2015; BRASIL, 2016; PARANA, 2016)

As condutas descritas no quadro 2 sugerem intervenções de identificação precoce do IAM, desde a avaliação pelo médico ou enfermeiro na sala de Classificação de Risco (conforme o protocolo de Manchester) até a intervenção diagnóstica e medicamentosa pelo clínico, emergencista e cardiologista.

Segundo Ribeiro (2018), estudos mostram que a alta mortalidade hospitalar do paciente com IAM no sistema público brasileiro está associada a dificuldades de acesso e baixa utilização do tratamento preconizado para o IAM, como terapia de reperfusão, medicamentos e cuidado em CTI.

O tratamento deve ser pautado na avaliação clínica e exames realizados. Contudo, a avaliação do ECG pode ter interferência pela pouca experiência do clínico; nesta situação,

Paraná (2016, p.22) sugere o uso da Telemedicina, descrita como

“prestação de serviços de saúde por meio do uso de informação e tecnologias de comunicação à distância. No caso da Linha de Cuidado do IAM, essa comunicação pode se dar entre dois profissionais de saúde ou por meio da transmissão de um eletrocardiograma para avaliação e indicação de conduta.

Também no contexto desta Linha Guia, somente são admitidas as teleconsultorias síncronas, isto é, comunicação em tempo real, haja vista o caráter de emergência do IAM.”

O tratamento medicamentoso sugerido, encontra-se descrito no quadro 3.

**Quadro 3: Atendimento Na Unidade De Emergência**

Prescrição	Indicação
<b>Alívio da Hipoxemia</b>	É indicada sua administração rotineira em pacientes com saturação de oxigênio < 94%, por cateter nasal ou máscara facial de 2 a 4 l/min, congestão pulmonar ou na presença de desconforto respiratório. Quando utilizada de forma desnecessária, a administração de oxigênio por tempo prolongado pode causar vasoconstricção sistêmica, e aumento da resistência vascular sistêmica e da pressão arterial, reduzindo o débito cardíaco, sendo, portanto, prejudicial.
<b>Analgesia</b>	Apesar de muitas vezes menosprezado, o controle da dor nos pacientes em vigência de IAM é essencial. Diminui o consumo de oxigênio pelo miocárdio isquêmico, provocado pela ativação do sistema nervoso simpático. A analgesia deve ser feita de preferência com sulfato de morfina endovenosa, exceto para pacientes alérgicos a esse fármaco, na dose inicial de 2 a 8 mg (geralmente suficiente para aliviar a dor e a ansiedade).
<b>Ácido acetilsalicílico</b>	O AAS deve ser administrado a todos os pacientes com IAM o mais rápido possível. As contraindicações para seu uso são hipersensibilidade conhecida, úlcera péptica ativa, hepatopatia grave ou discrasia sanguínea. A dose de ataque é de 160 a 325 mg mastigados, quando do primeiro atendimento, ainda antes da realização do ECG. e a de manutenção, de 100 mg ao dia.
<b>Clopidogrel e Ticagrelor</b>	Deve ser administrado em associação ao AAS precocemente no IAM, na dose de ataque de 300 mg (4 comprimidos de 75 mg) e mantidos 75 mg via oral ao dia. Seu benefício é observado tanto na utilização da terapia fibrinolítica quanto na angioplastia coronariana da fase aguda do IAM. Não utilizar dose de ataque em pacientes acima de 75 anos. O ticagrelor foi efetivo na redução de eventos em pacientes tratados na sala de emergência na dose de ataque de 180 mg seguida de 90 mg, duas vezes ao dia.
<b>Heparina não fracionada:</b>	É obrigatório o uso de heparina nos pacientes submetidos à terapia fibrinolítica com tenecteplase (TNK). Utilizar a dose de ataque de 60 U/kg de peso <i>in bolus</i> até o máximo de 4000 U. A dose de manutenção é de 12 U/kg/hora durante 48 horas, não ultrapassando 1000 U/hora. A dose deve ser ajustada a fim de manter o KPTT entre 50 a 70 segundos. A enoxaparina deve ser administrada quando do diagnóstico do IAM nas seguintes doses:

	<p>Em pacientes com idade &lt; 75 anos: 30 mg por via Intravenosa (IV) em bólus seguidas de 1 mg/kg de peso Subcutâneo (SC) a cada 12 horas até alta hospitalar.</p> <p>Em pacientes com idade ≥ 75 anos: não administrar o bólus e iniciar com 0,75 mg/kg SC a cada 12 horas.</p>
<b>Nitratos</b>	<p>Podem ser utilizados na formulação sublingual (nitroglicerina, mononitrato de isossorbida ou dinitrato de isossorbida), para reversão de eventual espasmo e/ou para alívio da dor anginosa. Também estão recomendados para controle da hipertensão arterial ou alívio da congestão pulmonar, se presentes. Estão contraindicados na presença de hipotensão arterial (Pressão Arterial Sistólica - PAS &lt; 90 mmHg), uso prévio de sildenafil ou similares nas últimas 24 horas e quando houver suspeita de comprometimento do Ventrículo Direito (VD). A dose sublingual preconizada é de nitroglicerina (0,4 mg), mononitrato de isossorbida (5 mg) ou dinitrato de isossorbida (5 mg). Devem ser administradas no máximo três doses, separadas por intervalos de 5 minutos.</p>
<b>Betabloqueadores</b>	<p>Na ausência de contraindicações, essa classe deve ser iniciada nas primeiras 24 horas do IAM. A recomendação atual é de se utilizar o betabloqueador por via oral nas primeiras 24 horas, reservando-se a via endovenosa para casos selecionados, como em pacientes hipertensos e taquicárdicos. Recomenda-se iniciar o betabloqueador e titular sua dose para um alvo de 60 batimentos por minutos. Pacientes com contraindicação para o uso precoce dos betabloqueadores devem ser reavaliados para candidatos a essa terapia na prevenção secundária.</p>
<b>Inibidores da enzima conversora da angiotensina (IECA)</b>	<p>É indicado para todos os pacientes com insuficiência cardíaca, fração de ejeção ≤ 40%, diabetes ou IAM anterior. Pode ser usado de rotina a partir das primeiras 24 horas do início do quadro de IAM. Recomenda-se o uso de captopril ou enalapril em doses iniciais baixas, conforme os níveis de pressão arterial do paciente e elevando a dosagem gradativamente.</p> <p><b>IECA NO IAM:</b> IECA Dose inicial Dose alvo Captopril 12,5 mg 2x ao dia 50 mg 2-3x ao dia. Enalapril 2,5 mg 2x ao dia 10 mg 2x ao dia</p>
<b>Estatinas</b>	<p>A simvastatina deve ser iniciada nas primeiras 24 horas do IAM na dose mínima de 20 mg sempre à noite e adequada a sua dose após a alta para atingimento da meta de colesterol LDL &lt;70 mg/dl.</p>
<b>Tenecteplase</b>	<p>Os fibrinolíticos são indicados para os pacientes com</p>

	<p>sintomas sugestivos de síndrome coronariana aguda associada a supradesnivelamento do segmento ST em ao menos duas derivações contíguas ou de um BRE novo, ou presumivelmente novo, no ECG, desde que não haja contraindicações. Deve ser utilizado o mais rápido possível no IAMCST, pelo fato de sua efetividade ser</p>
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| maior.

**Fonte:** (YUGAR, 2014; ISAA, 2015; BRASIL, 2016; PARANA, 2016)

Neste estudo não foi descrito ou instituído protocolo de atendimento ao IAM, no âmbito pré-hospitalar ou demais procedimentos a serem instituídos por especialistas. A reflexão sobre a intervenção dos protocolos sugeridos contribui com a equipe para intervenção precoce e minimização de danos.

## 2- Considerações finais

O desenvolvimento do presente estudo possibilitou uma análise de como a demora no atendimento de casos de IAM, pode agravar a situação do paciente e dificultar a abordagem por parte da equipe de emergência que os recebe.

O estabelecimento de protocolos e fluxogramas é de impacto na resolução dos casos de infarto, mas não substituem o conhecimento profissional e os dispositivos necessários para a assistência, como o acolhimento por Classificação de Risco, equipamentos para eletrocardiograma, exames laboratoriais e medicamentos específicos e suas condições técnicas de administração.

Dada à importância do assunto, torna-se necessário o desenvolvimento de treinamentos, programas que prepare os profissionais da área de saúde, principalmente da emergência, para que saibam abordar da melhor forma esses pacientes de IAM independente do tempo decorrido após os primeiros sintomas do infarto, para agilizar o melhor tratamento e evitar sequelas.

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